Wellness Coordination: Purpose

Wellness Coordination Services means the development, maintenance and routine monitoring of the waiver participant's Wellness Coordination Plan and the medical services required to manage his/her health care needs.

The new Wellness Coordination service is intended to provide more rigorous health care coordination for individuals on the Community Integration and Habilitation (CIH) waiver, specifically for those whose raw health scores are 5 or higher. Raw health scores are calculated from the Inventory for Client and Agency Planning (ICAP) addendums completed by State staff or State contractor as part of the Level of Care determination. Raw health scores will be made available to providers once the Advocare Provider Portal (discussed, below) has been opened for all Wellness Coordination providers.

These services extend beyond those services provided through routine doctor/health care visits required under the Medicaid State Plan, and are specifically designed for participants requiring assistance of a Registered Nurse (RN) or Licensed Practical Nurse (LPN) to properly coordinate their medical needs. ***Either an RN or LPN can fill this role as the Wellness Coordinator; however, if it is an LPN, he/she must be supervised by an RN.

Dependent upon an individual's raw health score, he/she will receive services through one of three tiers of service:

Tier I: Health care needs require at least weekly* consultation/review with RN/LPN, including face-to-face visits once a month.

Tier II: Health care needs require at least weekly* consultation/review with RN/LPN, including face-to-face visits twice a month.

Tier III: Health care needs require at least weekly* consultation/review with RN/LPN, including face-to-face visits once a week

*Weekly - a calendar week (Sunday-Saturday)

Assessments and Data Collection

In addition to meeting service definition requirements, providers must ensure that the RN/LPN who coordinates this service also completes wellness assessments and a wellness plan for each individual. Information collected through these assessments is important for the development of the individual's wellness plan, which drives his/her medical and health goals toward positive outcomes. These assessments and the plan are required to ensure the best medical and health coordination for each individual, and hold the provider accountable for the service as a component of its re-approval process.

DDRS has worked closely with the INARF/Arc Wellness Coordination Workgroup, as well as the Developmental Disabilities Nursing Association (DDNA) to develop these assessments and a guide for the wellness plan; their expertise lends itself to understanding the medical and health needs of individuals with developmental disabilities. There are three documents specific to an individual's medical/health care needs to which providers will be given access through the Advocare system: *Wellness Assessment, Risk Mitigation Tool, and Wellness Plan Guide*. They

are intended for use by Wellness Coordinators in assessing only the medical and health needs of an individual.

There are seven outcome data points the State seeks to measure immediately for individuals receiving this service:

1. Height, Weight and BMI
2. Annual flu vaccinations
3. Annual physician/exam
4. Annual dental visits
5. Five (5) percent decrease in the number of medication administration errors in incident reports over a 12 month period
6. Five (5) percent decrease in the number of choking incidents that require intervention over a 12 month period
7. Five (5) percent decrease in the number of falling incidents that require intervention over a 12 month period

All Wellness Coordination providers are required to begin collection of this data, immediately, and will be asked to enter this information into the Advocare system for outcomes 1, 2, and 3.

The following are key points regarding collection of this information:

- Providers ***may*** use the *Wellness Assessment* template to evaluate these individuals, as it includes all of the information and data points the State would like to collect.

  If a provider chooses to utilize the *Wellness Assessment* template that has been uploaded into the Advocare Provider Portal, it will have to be used as a paper copy at this time; data points for numbers 1, 2, 3, and 4 will have to be manually entered into the Provider Portal on a **quarterly** basis. There are plans to incorporate the current template as an online fillable form in the system in coming months.

- Providers ***may*** use their own assessments; however, they **must** include the data points being sought as the outcomes listed above. For those Providers who choose to utilize their own form for the wellness assessment, they will be required to enter this information into Advocare's Provider Portal on a **quarterly basis**.

- Providers are still welcome to use their own assessments for other purposes, such as those pertaining to social, behavioral, or active treatment needs, as this assessment does not include such information.

For outcomes 5, 6, and 7, this information will be obtained through the BQIS data system based upon the incident reports providers are required to submit.

The *Risk Mitigation Tool* is **required** to be completed in the Advocare system by Wellness Coordinators. Together, the *Wellness Assessment* and *Risk Mitigation Tool* comprise the information necessary to develop a *Wellness Plan*. A suggested set of guidelines is also posted in Advocare, and is intended to help structure the Wellness Plan for an individual's medical and health needs.

These documents were also developed in concert with the outcomes for Indiana as they relate to the National Core Indicators the standard measures used across states to assess the outcomes of services provided to individuals and families. All information collected will be utilized to assess

the effectiveness of the service at the individual, provider, and State levels. For any Wellness Coordination provider, this information will also be utilized during the provider re-approval process conducted by BQIS. Further information will be released regarding the baseline data for each of the outcomes listed above.

Wellness Coordination Service Process

Auto-Enrollment

As of April 1, 2014, those consumers who have a raw health score of 5 or above and are receiving services through a Residential Habilitation/Support (RHS) or Structured Family Caregiver (SFC) provider approved to provide Wellness Coordination will be auto-enrolled into the service with that provider. These individuals will be identified in the state's DART, INsite, and Medicaid systems through a particular code or flag as being enrolled into the service.

These individuals will be informed by the State via U.S. mail of their auto-enrollment into the Wellness Coordination service, including:

- a brief description of the Wellness Coordination service
- their choice in receiving services through the auto-assigned provider, or selecting another Wellness Coordination provider
- information about how to opt-out of receiving the service. Individuals who have been auto-assigned to a Wellness Coordination provider may opt-out at any time, without jeopardizing their existing Medicaid Waiver services.

The service will be added to the most current approved and pending CIH Waiver Cost Comparison Budgets (CCBs) for these individuals, using April 1, 2014, as the initial service start date on the Notice of Action (NOA).

CCBs will be converted to add the following Tiers of Wellness Coordination:

- Tier 1 if the consumer's Health Score is 5 or 6;
- Tier 2 if the consumer's Health Score is 7, 8, or 9;
- Tier 3 if the consumer's Health Score is 10.

One unit of Wellness Coordination will be added to the CCB, starting in April 2014, and will continue through the end of the budget.

The provider of Wellness Coordination will be added to the CCB as follows:

1. The RHS or SFC service provider of an individual if that provider has been approved by DDRS to provide Wellness Coordination;
2. "To Be Determined" if the RHS or SFC provider of an individual has not been approved by DDRS to provide Wellness Coordination; or
3. "To Be Determined" if the individual does not receive RHS or SFC services.

In the case of the second or third scenario, the individual may choose a Wellness Coordination service provider from a pick list.

Wellness Coordination Provider Timeline

Wellness Coordination providers will receive notification from the State regarding all individuals who:

- are auto-assigned to that provider
- choose that provider from a picklist
- opt-out of the service

If a provider intends to bill for the month of April, a face-to-face meeting between the Wellness Coordinator and the individual must occur within 30 days. All face-to-face meetings, the Wellness Assessments, Risk Mitigation Tool and Wellness Plan must be conducted or developed within **60 days of April 1, 2014.**

For questions related to this guide or other facets of the Wellness Coordination service and its process, please contact BQISHelp@fssa.in.gov.